Extension of Medicare Immunosuppressive Drug Benefits: A "No Brainer" that Did not Happen

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In addition to having the privilege of serving as Editor-in-Chief of the *Clinical Journal of the American Society of Nephrology*, I necessarily have a day job. For the past 40 years, I have functioned clinically as a renal transplant physician. Currently there is little disagreement that patients who receive a renal transplant have superior outcomes in terms of length and quality of life compared with similar patients who remain on dialysis but who are on the transplant waiting list (1). In 2010, transplantation is denied to patients who cannot afford their immunosuppressive medications and increasingly for those who have only Medicare coverage because their reimbursement benefit runs out after 36 months.

In the current debate about health care reform, there was bipartisan agreement that extension of these immunosuppressive benefits for the lifetime of the transplant made good clinical and economic sense because Medicare pays for dialysis for the duration of a patient's life, a much more expensive therapy than kidney transplantation. This common sense addition to the health care reform bill was scuttled by the Senate because of input from many lobbying groups, including those associated with the dialysis industry and the National Kidney Foundation. This seems counterintuitive to most of us involved in caring for transplant patients.

The complex issues involved in these legislative processes are discussed in two editorials by prominent transplant physicians in this issue of *CJASN*. The goal of these editorials is to inform the nephrology community about what has transpired and the consequences of professional organizations being in lock step with industry, which has a different perspective on what is best for patients.

Undoubtedly, pitting the interests of one group of patients against those of another was not the goal of any professional society or corporation. However, this does not obviate the fact that in 2010, patients who are good candidates for the preferred form of therapy in ESRD will be excluded from transplantation for reasons that make no logical sense.

Disclosures

None.

Reference

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